CAREY B. STROM, M.D.

8631 West 3rd Street, Ste. 1017E, Los Angeles, CA 90048

Account No.	**Patient Registration**	Date

Personal Information

Patient Name (Last, First, MI)		Address	
Social Security#		City, State	Zip Code
Date of Birth	Sex	Home Phone Preferred Number:	Cell Phone Preferred Number:
Martial Status Single Married Other		E-Mail Address	
Primary Language		Your Regular Physician Phone No.	
Ethnicity Race Religion		Referring Physician Phone No.	

Employment Information

Employment Status (Circle One) Full Time Part Time Self Employment Not Employed Retired (Date) Student	
Name of Employer/Union/Guild	Occupation Work #
Employer Address	Employer City, State, ZIP

Additional Information

Driver's License State	Mother's Maiden Name	Place of Birth City & State	Pharmacy Name
Driver License ID	Patient's Maiden Name		Pharmacy Phone

Emergency Contact

Name	Relationship	Home Phone	Work Phone
Address, City	State, Zip Code	Legal Guardian Yes No	Cell Phone

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Insurance Information

Primary Insurance	Code	Subscriber ID#	Phone Number

Effective Date	Subscriber Name & Date of Birth	Group#	Group Name

Primary Insurance Claim Address

Secondary Insurance	Code	Subscriber ID#	Phone Number

Effective Date	Subscriber Name & Date of Birth	Group#	Group Name

Secondary Insurance Claim Address

Third Party Billing (Or Remarks)

Street Address	City, State	Zip Code

- AUTHORIZATION TO PAY -

I hereby authorize my insurance provider to pay the physician responsible for my care directly. **I understand that Carey B. Strom, M.D. is not a contracted provider of any insurance policies other than Medicare, but as a courtesy will bill my insurance for the out of network benefits where applicable** and authorize the release of my medical records to my third party payer in order to obtain payment. I fully understand that my insurance may not cover all of the charges and that I am responsible for payment of my account. In the event that my insurance policy issues payment to me, I agree to forward full payment to the rendering physician immediately. I further understand that in the event that my account remains unpaid after 120 days it will be subject to a 6% interest charge. Please be advised that we will attempt to get your procedure pre-certified but it is ultimately your responsibility.

SIGNATURE: ______________________________ **DATE:** ________________

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NOTICE OF PRIVACY PRACTICES

To Our Patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information.

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by law enforcement official.
4. When necessary to reduce or prevent serious threat to your health and safety or the health and safety of another individual or the public. We shall only make disclosures to a person or organization able to help prevent a threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request, however, if we do agree, we are bound by our agreement except when otherwise required by law, emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the Office Manager.

4. You may ask us to amend your health information if you believe it is incorrect or incomplete and as long as the information is kept for or by our practice. To request an amendment, your request must be in writing and submitted to the Office Manager. You must provide us with a reason that supports your request for amendment.

5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact our front desk receptionist.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice, or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the Office Manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. If you have any questions regarding this notice or our health information privacy policies, please contact the Office Manager.

8. Our office will make every attempt to get authorization for your procedure but it is ultimately your responsibility.

9. Telemedicine visits are to be billed at customary rates.

I, hereby acknowledge that I have been presented with a copy of Carey B. Strom, M.D., Notice of Privacy Practices.

Signature ____

Print Name ____

Date ____

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Patient Record of Disclosures

In general, the HIPAA privacy rule gives the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply)

HOME TELEPHONE #____
_______Ok to leave message with detailed information
_______Leave message with call back number only

WORK TELEPHONE #____
_______Ok to leave message with detailed information
_______Leave message with call back number only

CELLULAR TELEPHONE #____________________________________
_______Ok to leave message with detailed information
_______Leave message with call back number only
_______Ok to text message

WRITTEN COMMUNICATION
_______Ok to mail to my home address
_______Ok to mail to my work/office address
_______Ok to fax to this number__________________________________

If you would like to give our office permission to discuss your protected health information and your account/billing information with your spouse or any other individual, PLEASE LIST THE NAMES OF THOSE INDIVIDUALS HERE:

____
____
____
____

OTHER INSTRUCTIONS____
____
____

Patient Signature___________________________________Date___________________

Print Name_______________________________________Date of Birth_____________

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HEALTH HISTORY QUESTIONNAIRE – GASTROENTEROLOGY

Patient Name: ___________________________________
MRN: _____________________
Date of Appointment: _______/_______/________(mm/dd/yy)

Please fill this form out as completely as possible.

PAST MEDICAL HISTORY – *place a checkmark in the box next to any medical problems you have had in the past*

Anemia		Diabetes		Lactose Intolerance	
Anxiety/Depression		Diverticulitis		Liver Disease	
Barrett's Esophagus		Heart Disease		Lung Disease	
Bleeding Disorder		Heartburn		Pancreatitis	
Bowel Obstruction		Hemorrhoids		Sleep Apnea	
Cancer		Hepatitis A		Stroke	
Type:		Hepatitis B		Thyroid Disease	
Celiac		Hepatitis C		Ulcer	
Cirrhosis		High Blood Pressure		Ulcerative Colitis	
Colon Polyps		Irritable Bowel Syndrome		Other (please specify below)	
Crohn's Disease		Kidney Disease			

PAST SURGICAL HISTORY – *place a checkmark in the box next to any surgeries you have had and the date of surgery if you know it*

Appendectomy		Coronary Artery Surgery		Stomach Surgery	
Bowel Resection		Gallbladder Surgery		Thyroid Surgery	
Breast Surgery		Heart Surgery		Other (please specify below)	
Colon Surgery		Obesity Surgery			

IMMUNIZATIONS: If yes, give the approximate year given

□ Pneumococcal Date_________________
□ Hepatitis A Date_________________
□ Hepatitis B Date_________________
□ Tetanus Date_________________

Have you ever had a colonoscopy?
□ Yes □ No Date______________
Findings____

Have you ever had an upper endoscopy?
□ Yes □ No Date______________
Findings____

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MEDICATIONS – *Please list any medication(s) you currently take, including over-the-counter medications*

Name	**Dose** (mg, number of tablets, etc)	**How often** (once a day, twice a day, only as needed, etc)

ALLERGIES
Do you have any allergies to medications, Latex, or foods?
Please list them along with reaction. If none, please write none.

SOCIAL HISTORY

Tobacco Use

- ☐ Never smoked
- ☐ Former smoker
- ☐ Every day smoker
- ☐ Heavy smoker
- ☐ Light smoker
- ☐ Passive smoke exposure – secondhand smoke

Alcohol Use

Do you ever drink alcohol? Yes / No

If yes, please indicate the type and quantity per week:

Drug Use

Do you use recreational drugs? Yes / No

If yes, please indicate what type:

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FAMILY HISTORY – *place a checkmark to report problems your family members have had.* ***Please state the age when they had the problem, if you know it.***

☐ I was adopted, so I do not know my family history.

	Mother	Father	Sister	Brother	Son	Daughter	Other
	Alive?	Alive?	Alive?	Alive?	Alive?	Alive?	
Barrett's Esophagus							
Bleeding Problem							
Celiac Disease							
Colon Cancer							
Colon Polyps							
Crohn's Disease							
Diabetes							
Esophageal Problems							
Esophageal Cancer							
HIV/AIDS							
Hemorrhoids							
H-Pylori							
Irritable Bowel Syndrome							
Lactose Intolerance							
Liver Disease							
Pancreas Disease							
Psychiatric Disease							
Stomach Cancer							
Reflux							
Ulcerative Colitis							

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8631 West 3rd Street, Ste. 1017E, Los Angeles, CA 90048

310-550-0400
310-285-0482 Fax
www.doctorstrom.com

MEDICAL RECORD RELEASE AUTHORIZATION

TO:____
(DOCTOR/OFFICE/HOSPITAL)

____
(ADDRESS/FAX NUMBER)

I, * _________________________ give my authorization to release all my medical records to the following person:

Carey B. Strom, M.D., FASGE
8631 West 3rd Street, Ste. 1017E,
Los Angeles, CA 90048
Or
Fax to office at 310-285-0482

*Name of patient____

*Address____

*Birthdate________________________________

*Signature________________________________

*Date____________________________________

***Fill these sections only**

CAREY B STROM MD
8631 West 3rd St, Suite 1017 E
Los Angeles CA 90048

Please Only Fill If You Are A Non-Medicare Patient

PHYSICIAN NETWORK STATUS
I understand that Dr. Carey Strom is an OUT OF NETWORK provider and all procedures will be billed at an OUT OF NETWORK rate. I understand that Dr. Strom will submit an insurance claim on my behalf for the OUT OF NETWORK benefits as a courtesy.

INITIALS__________

ANESTHESIA SERVICES
I understand that my insurance may not cover anesthesia services and that I am responsible for the payment of all anesthesia related charges. I understand that the anesthesia fee is separate from all other fees and that I will be responsible for payment at the time of service or will be billed at a later date.

INITIALS__________

LABORATORY SERVICES
I understand that if Dr. Carey Strom determines that specimens from my procedure need laboratory testing, I will receive a separate bill from the laboratory and I am responsible for any charges incurred.

INITIALS__________

PATHOLOGY SERVICES
I understand that if Dr. Carey Strom determines that biopsies are to be taken during my procedure, I will receive a separate bill from the UCLA Department of Pathology for the processing of the slides. I understand I will also receive a separate bill from Tower Pathology Associates for the reading of the slides.

INITIALS__________

FACILITY SERVICES
I understand that the Surgery Center of Beverly Hills, (424) 382-1137, and/or Cedars Sinai Medical Center, (800) 233-2771, are contracted with many insurance companies but maybe not mine. It is ultimately my responsibility to call these facilities to check. I further understand that this bill is separate from all others and is my financial responsibility.

INITIALS__________

There is a 3% credit card fee. **INITIALS__________**

______________________________ ______________________________
Patient's Signature **Date**

____
Patient's Printed Name

Carey B. Strom, M.D. has financial interest in
The Surgery Center of Beverly Hills

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for **D.**_______________below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____________below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Virtual visits and phone calls within 7 days of your last visit.		**$50 to $125**

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____________listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.
☐ **OPTION 1.** I want the **D.**_____________listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
☐ **OPTION 2.** I want the **D.**_______________listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.
☐ **OPTION 3.** I don't want the **D.**_____________listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

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CAREY B. STOM, M.D.,FASGE

8631 WEST 3RD STREET, SUITE 1017E

LOS ANGELES, CA 90048

(310)-550-0400

Telehealth Informed Consent

Tele-health is healthcare provided by any means other than face to face visit. It is certainly a major convenience, especially since it was implemented during the COVID-19 pandemic. Most patients find it very convenient to talk to their doctor without leaving their home through telephone conversation, video conferencing, such as with Skype, FaceTime, Zoom, or other similar services. However, I realize that they may not provide a secure HIPAA compliant platform.

I understand that tele-health billing information is collected in the same manner as a regular office visit. Medicare covers tele-medicine as well as most insurance companies, but it will be ultimately my financial responsibility to check with my insurance plan to determine coverage.

I understand and agree that a medical evaluation via tele-health may limit my healthcare provider's ability to fully diagnose a condition or disease which may further warrant an in-person evaluation. As the patient, I agree to accept responsibility for following my healthcare providers recommendation, including further diagnostic testing, such as lab testing, imaging studies, or endoscopies.

To the extent permitted by law, I agree to waive and release my healthcare provider and his practice from any claim I may have about the tele-health visit.

I certify that I have read and understand this agreement prior to my signature, with the opportunity to have questions answered to my satisfaction.

Name (Print): ____

Signature:____

Date: ____